JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	28 - 30 MARCH 2023
DELIVERED	**:**	26 MAY 2023
FILE NO/S	**:**	CORC 206 of 2020
DECEASED	**:**	TAULELEI, JACOB GEORGE ISAAC

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr J. Tiller assisted the coroner.

Ms R. Panetta (State Solicitor's Office) appeared for the East Metropolitan Health Service.

Ms R. Young SC (instructed by MinterEllison) appeared for St John of God Health Care Inc., and Dr S. Schutte.

Mr S. Denman (Scott Denman Lawyer) appeared for Dr F. English.

Mr E. Panetta and Ms C. Catto (Panetta McGrath) appeared for Dr G. Farrell and Dr S. Curtin.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Jacob George Isaac TAULELEI*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 28 - 30 March 2023, find that the identity of the deceased person was* ***Jacob George Isaac TAULELEI*** *and that his death occurred on 8 February 2020 on train tracks adjacent to Railway Parade, Midland, from multiple injuries in the following circumstances:*

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INTRODUCTION

1. Jacob George Isaac Taulelei (Mr Taulelei) died at 12.30 am on 8 February 2020, after he was struck by a train on tracks adjacent to Railway Parade in Midland. He was 28-years of age.[1,2,3,4] Mr Taulelei had a long-standing history of mental health issues, and he and his mother (Ms Wendy James) presented to St John of God Midland Public Hospital (SJOG) on 5 February 2020. Although Mr Taulelei told clinical staff he wanted to jump in front of a train or bus, he was discharged into his mother's care, and referred to a community mental health service, and his GP.

2. On 7 February 2020, Mr Taulelei sent a Facebook message to his mother containing a link to a song he said he wanted played at his funeral. She took him back to SJOG, where Mr Taulelei again told staff he planned to jump in front of a bus or train. Before she left SJOG to go home, a doctor told Ms James that Mr Taulelei would be admitted to the mental health unit. In fact, Mr Taulelei was discharged home shortly before midnight and further, although Ms James had specifically asked to be told if Mr Taulelei left SJOG, this did not occur.

3. Ms James and members of Mr Taulelei's family attended the inquest I conducted into his death in Perth on 28 - 30 March 2023. The inquest focussed on the care and treatment provided to Mr Taulelei by SJOG, and the circumstances of his death. Two volumes of documentary evidence were adduced at the inquest, and the following witnesses gave evidence:

a. Dr Grainne Farrell (Psychiatric registrar, SJOG);
b. Dr Shona Curtin (Emergency Department registrar, SJOG);
c. Dr Fred English (Emergency Department registrar, SJOG);
d. Dr Mrinalini Sharma (Psychiatric registrar, SJOG);
e Dr Mark Hall (Independent consultant psychiatrist);
f. Dr Stefan Schutte (Consultant psychiatrist/policy witness, SJOG); and
g. Ms Wendy James (Mr Taulelei's mother).

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (17.04.20)
[2] Exhibit 1, Vol. 1, Tab 3.1, Life Extinct form (08.02.20)
[3] Exhibit 1, Vol. 1, Tab 3.2, P92 - Identification of Deceased Person - Other than by Visual means (11.02.20)
[4] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (27.03.20)

MR TAULELEI

Background[5,6]

4. Mr Taulelei was born in New South Wales on 24 April 1991, and came to Western Australia with his family in 1993. He lived with Ms James in Swan View, and she described him as a caring and gentle person, who loved animals and his family. Ms James also said Mr Taulelei enjoyed helping others, and at the time of his death, he had been developing a computer program to assist inmates understand what supports they needed when they were released from prison.

5. Mr Taulelei had two children from separate relationships, but was prevented from seeing them by the children's respective mothers. His estrangement from his children caused Mr Taulelei very significant distress and as I will explain, was cited by him as being the cause of his suicidal feelings.

Medical history[7,8,9,10]

6. Mr Taulelei's medical history included long-standing depression and anxiety with associated suicidal ideation and previous self-harm and suicide attempts. Ms James said that when Mr Taulelei spoke about his mental health issues, he did so in the following terms:

> He called it…the darkness. He said it was like a massive amount of energy would hit his body and everything would be dark for him. But he would be in all this pain, both physically and mentally.[11]

7. Mr Taulelei was also diagnosed with chronic regional pain syndrome in relation to an injury to his hand that occurred when he struck a wall whilst he was an inpatient in New South Wales in 2014. According to Ms James, the injury occurred after Mr Taulelei had a "*bad reaction*" to some anti-psychotic medication he was given, however the injury has also been described as having occurred during a panic attack.

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[5] Exhibit 1, Vol. 1, Tab 6, Statement - Ms W James (09.02.20), paras 3-15 and ts 30.03.23 (James), pp201-203 & 211
[6] Exhibit 1, Vol. 1, Tab 2, Memo - Const. S Warhurst (17.04.20), p2
[7] Exhibit 1, Vol. 1, Tab 6, Statement - Ms W James (09.02.20), paras 16-18 and ts 30.03.23 (James), pp202-203
[8] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), pp6-7 and ts 29.03.23 (Hall), pp157-160
[9] Exhibit 1, Vol. 1, Tab 2, Memo - Const. S Warhurst (17.04.20), pp2-3
[10] Exhibit 1, Vol. 1, Tab 12, Report - Dr A Chudasama (09.03.20)
[11] ts 30.03.23 (James), p202

8. According to his GP, Mr Taulelei initially neglected the injury to his hand, and when he eventually sought orthopaedic and physiotherapy reviews he was told no surgical interventions were available.

9. Mr Taulelei's GP first saw him in relation to mental health issues on 9 March 2019. During that consultation, Mr Taulelei denied any suicidal ideation, but did disclose a history of deliberate self-harm and attempted suicide. Mr Taulelei's GP prepared a mental health care plan and referred him to the Midland Adult Community Mental Health Service (MACMHS), and a psychologist. Mr Taulelei was subsequently referred to Perth Clinic and prescribed diazepam for use if he experienced a panic attack. Mr Taulelei was also referred to a chronic pain management service but was discharged when he did not attend follow-up appointments.[12]

10. According to his GP, Mr Taulelei continued to have "*ongoing psychology*", and remained "*relatively stable with regard to ongoing chronic pain management and mood*" until December 2019. Mr Taulelei was also diagnosed with haemochromatosis (an inherited condition causing the body to absorb and store too much iron) and Pyrrole disorder. Pyrrole disorder can cause nutritional deficiencies, particularly zinc and vitamin B6, and affects the synthesis of haemoglobin. In Mr Taulelei's case, the condition was also said to exacerbate his depression.

Mental health history[13,14,15]

11. Mr Taulelei's involvement with mental health services began during his childhood. Notes from a presentation to Sir Charles Gairdner Hospital (SCGH) on 30 October 2010 state that Mr Taulelei had "*seen seven or eight psychiatrists since the age of 13 or 14 years*".[16] Mr Taulelei received several mental health diagnoses over the years including: Cluster B personality style (2010), Cluster B personality disorder (2013), mixed anxiety and depressive disorder (2019), and panic disorder and post-traumatic stress disorder (2020) and his interactions with mental health services included:

[12] Exhibit 1, Vol. 1, Tab 17.1. Facsimile - Black Swan Health Ltd to Dr A Chudasama (13.09.19)
[13] Exhibit 1, Vol. 1, Tab 6, Statement - Ms W James (09.02.20), paras 16-18 and ts 30.03.23 (James), pp202-203
[14] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), pp6-14
[15] Exhibit 1, Vol. 1, Tab 12, Report - Dr A Chudasama (09.03.20)
[16] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), p7 and ts 29.03.23 (Hall), pp157-160

a. *July 2010 - Joondalup Health Campus*: reported feeling depressed and suicidal and when angry, he would "*smash things up*" which he would later regret. No diagnosis was made and Mr Taulelei was referred for anger management;

b. *October 2010 - SCGH*: Mr Taulelei reported hitting himself, anxiety, and blackouts. Diagnosed with Cluster B personality style. A diagnosis of autism spectrum disorder was also queried, and he was referred to a community mental health service (CMHS);

c. *November 2010 - CMHS*: Mr Taulelei reported having issues with anger management, and was experiencing blackouts;

d. *October and November 2012 - CMHS*: Mr Taulelei reported cannabis-induced psychosis, aggression and hostility. He was referred to a rehabilitation service regarding his cannabis use, and to his GP for a mental health plan with psychological counselling;

e. *2014*: Mr Taulelei had two voluntary inpatient admissions in New South Wales relating to psychotic episodes;

f. *September 2015 - CMHS*: Mr Taulelei reportedly displayed psychotic and delusional behaviour and was referred to a rehabilitation service, and his GP;

g. *12 December 2018 - SJOG*: brought to emergency department (ED) by Ms James. Described suicidal thoughts and anxiety after ceasing opiates. Left against medical advice, referred to CMHS;

h. *22 December 2018 - SJOG*: brought to ED by Ms James with a history of depression and described previous suicide attempts. Diagnosed with overuse of pain relief, post-traumatic stress disorder, and somatisation and referred to his GP and CMHS;

i. *March 2019 - GP*: complained of ongoing panic attacks and inability to leave home. Referred to CMHS, and later to a private psychiatrist;

j. *December 2019 - GP*: saw GP twice. First visit: reported a flare-up of anxiety and somatic symptoms. Second visit: described poor memory and a homeless person entering his house. Opiate dose reduced; and

k. *January 2020 - GP*: saw GP on two occasions. First visit: said the activities of the homeless person had ceased. The dose of his opiate medication was further reduced. Second visit: Mr Taulelei reported feeling very down and low.

EVENTS LEADING TO MR TAULELEI'S DEATH

Attendance at SJOG - 5 February 2020[17,18,19,20,21,22]

12. In the weeks leading up to 5 February 2020, Mr Taulelei had been isolating himself in his room, not showering, and sleeping excessively. He was also expressing suicidal thoughts to his mother, and is said to have attempted to take his life using a knife. He had also been telling his mother he was "*not feeling safe*" in the week before his death, and she understood him to mean that he was planning to take his life.

13. Due to her concerns for Mr Taulelei's mental health, Ms James took him to SJOG at about 5.00 pm. Mr Taulelei was seen by a triage nurse who described his speech as "*slow*" with "*low tone*". Mr Taulelei told the triage nurse he wanted to "*jump in front of a bus/train*". He also said it was his son's birthday soon, that he "*wanted to die*", and that he "*could just cut his wrists*". The triage nurse also noted that Mr Taulelei said he had taken four diazepam tablets at 4.00 pm but they were "*not helpful*".[23]

14. Mr Taulelei was reviewed by an ED resident medical officer (RMO) at about 6.30 pm. He described recent low mood and suicidal thoughts, and said he had tried to "*cut his wrist*", and Mr Taulelei again said he wanted to jump in front of a bus/train. The RMO noted Mr Taulelei was "*closing his eyes and hiding them with his arm*" and that his speech was "*monotonous*". Ms James told the RMO her son had been isolating himself and expressing suicidal thoughts over the previous few days, and mentioned that Mr Taulelei was not in touch with his son whose first day of school was coming up.[24]

15. Mr Taulelei was referred to the psychiatric team, and he was reviewed by a psychiatric registrar (Dr Grainne Farrell), in his curtained ED cubicle at about 7.45 pm.[25]

[17] Exhibit 1, Vol. 1, Tab 6, Statement - Ms W James (09.02.20), paras 16-26 and ts 30.03.23 (James), pp204-206
[18] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), pp14-16 and ts 29.03.23 (Hall), pp160-164
[19] Exhibit 1, Vol. 1, Tabs 15.12 & 15.13, SJOG Mental Health Assessment (05.02.20)
[20] Exhibit 1, Vol. 1, Tab 25, Statement - Dr G Farrell (22.03.23), paras 26-55 and ts 28.03.23 (Farrell), pp19-35
[21] Exhibit 1, Vol. 1, Tab 15.10, SJOG Adult Emergency Department Record (05.02.20)
[22] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), pp12-16
[23] Exhibit 1, Vol. 1, Tabs 15.10, SJOG Adult ED Record (05.02.20)
[24] Exhibit 1, Vol. 1, Tabs 15.10, SJOG Progress Notes (6.30 pm, 05.02.20)
[25] Exhibit 1, Vol. 1, Tabs 15.10, SJOG Progress Notes (7.45 pm, 05.02.20)

16. Dr Farrell noted Mr Taulelei's psychiatric history, and his increasingly intrusive thoughts of self-harm and suicide in the context of distress at not being able to see his son. Mr Taulelei described his low mood over the past week and trying to cut himself with a knife which "*wasn't sharp enough*". Mr Taulelei also disclosed an intention to end his life and having made a Facebook post saying: "*The End*". However, he said that when family members reached out to him, he had decided to seek help.[26]

17. Mr Taulelei told Dr Farrell he "*did not feel happiness*", had contemplated different ways to end his life, and felt overwhelmed by "*the amount of options*". As Mr Taulelei sat on the ED hospital bed with his face in his hands, he also told Dr Farrell he "*could not guarantee his safety at home*". Mr Taulelei also told Dr Farrell he disliked socialising and crowds, and wanted to explore "*an anti-psychotic medication option as an inpatient*". Dr Farrell also referred to "*some bizarre content*" in what Mr Taulelei was saying, noting he had described a previous self-harm attempt by way of "*big game hunting for crocodiles*", and said that some years before he was involved in "*the drug world*" and had "*some enemies from that time*".[27]

18. Dr Farrell's assessment was that Mr Taulelei was experiencing stress associated with "*difficult memories*" about his estranged son's birthday, and low mood with "*ongoing suicidal ruminations without active plan or intent*". Dr Farrell completed a Brief Risk Assessment (BRA) and determined Mr Taulelei was at "*moderate*" risk for suicide and that he should be admitted to SJOG's mental health unit (MHU) as a voluntary patient. Dr Farrell made the following entry in the medical notes:

> Voluntary admission. Medication review on ward. Repeat risk assessment if requesting discharge with GP and ?(Community Mental Health Team) follow up as agreeable".[28,29,30]

[26] Exhibit 1, Vol. 1, Tabs 15.10, SJOG Progress Notes (7.45 pm, 05.02.20)
[27] Exhibit 1, Vol. 1, Tabs 15.10, SJOG Progress Notes (7.45 pm, 05.02.20)
[28] Exhibit 1, Vol. 1, Tab 15.13, Brief Risk Assessment (created at 10.01 pm on 05.02.20)
[29] Exhibit 1, Vol. 1, Tabs 15.10, SJOG Progress Notes (7.45 pm, 05.02.20)
[30] Exhibit 1, Vol. 1, Tab 15.12, SJOG Mental Health Assessment (05.02.20)

19. By 9.00 pm Mr Taulelei was still in the ED waiting for a bed in the MHU, and a nursing entry in the ED notes at this time states: "*Awaiting bed upstairs (voluntary admission)*".[31] Although Mr Taulelei had told staff he was unhappy with the level of noise in the ED, he declined an offer to be moved to a quieter area. When Dr Farrell reviewed Mr Taulelei for the second time at 10.00 pm, he was still in the ED.

20. In her email to Dr Armit Banerjee (who was the then Head of the Department, Psychiatry)[32] on 26 February 2020, Dr Farrell said that the "*original decision*" discussed between her and Mr Taulelei was that he would be admitted voluntarily. However, Dr Farrell said she was informed "*there were no beds at that particular time*" and it was unlikely there would be a bed in the MHU that night. Dr Farrell also said she was "*unsure about state-wide beds*".[33,34]

21. In her statement to the Court, Dr Farrell said it would have been unusual for her to review Mr Taulelei "*so soon after the initial review*" and that she suspected another staff member "*would have prompted me to re-review him*". Dr Farrell noted that Mr Taulelei was "*now thinking more clearly*", had no further thoughts of self-harm, and "*felt happy that he could stay safe at home*". Dr Farrell also gave Mr Taulelei "*emergency numbers*" which he said he would be happy to contact "*if struggling*".[35,36]

22. In her email to Dr Banerjee, Dr Farrell says she told Mr Taulelei "*everything was completed and ready*" but that there wasn't a bed available "*at that moment*". As noted, although Mr Taulelei told her he was unhappy about the level of noise and activity in the ED and preferred quiet environments, he declined to be moved to a quieter section of the ED. Dr Farrell confirmed Mr Taulelei had told her he could "*guarantee his safety at home*", denied ongoing suicidal thoughts, and agreed to follow up with the "*community team on an urgent basis*".[37]

[31] Exhibit 1, Vol. 1, Tabs 15.8, SJOG Adult ED Record (9.00 pm, 05.02.20)
[32] ts 29.03.23 (Schutte), pp180-181
[33] Exhibit 1, Vol. 2, Tab 29.18, Email - Dr G Farrell to Dr A Banerjee (26.02.20)
[34] See also: Exhibit 1, Vol. 2, Tab 29.9, Daily Hospital Inpatient Activity (05.02.20)
[35] Exhibit 1, Vol. 1, Tab 25, Statement - Dr G Farrell (22.03.23), paras 38-39
[36] Exhibit 1, Vol. 1, Tabs 15.10, SJOG Progress Notes (10.00 pm, 05.02.20)
[37] Exhibit 1, Vol. 2, Tab 29.18, Email - Dr G Farrell to Dr A Banerjee (26.02.20)

23. Following Dr Farrell's second review, Mr Taulelei's management plan was amended and he was discharged into Ms James' care and referred to his GP and MACMHS. Dr Farrell noted that Mr Taulelei had been reluctant for his mother to be contacted and had "*wanted to go home by Uber*". However, Dr Farrell says she explained to Mr Taulelei that in situations like his "*we like to involve the family*". Thus, despite Mr Taulelei's initial reluctance, Dr Farrell contacted Ms James to advise her of the new plan.[38]

24. Ms James expressed her concerns and told Dr Farrell that Mr Taulelei was "*not good at attending appointments*". Nevertheless, Dr Farrell said she was referring Mr Taulelei to the community mental health team, and the medical notes state that "*She* (i.e.: Ms James) *is happy to pick him up*". Thus, despite his presentation at 7.45 pm being sufficiently concerning to warrant a voluntary admission to the MHU, Mr Taulelei was discharged into his mother's care at about 11.00 pm.[39]

25. In a letter to the family after Mr Taulelei's death, the then Director of Medical Services at SJOG, Dr Sayanta Jana, said Mr Taulelei had asked to be discharged and said he could "*stay safe at home*". Despite these assertions, Ms James says SJOG staff had told her that Mr Taulelei was being discharged because there were "*no free beds*". In his letter, Dr Jana confirmed this was the case (at least at 9.00 pm) and a clinical investigation conducted after Mr Taulelei's death (SAC1) also referred to the fact that at the relevant time there were no free beds.[40,41,42]

26. In her statement to the Court, Dr Farrell noted:

> I reflected on Mr Taulelei shortly after I was informed of his passing. I reflected on whether I should have detained him or not. I recall thinking that he did not meet the criteria for detention because I had perceived that he was not a significant risk to himself at that time, he had the capacity to make his own decisions, and reasonable treatment in the community could be provided which was less restrictive.[43]

[38] Exhibit 1, Vol. 2, Tab 29.18, Email - Dr G Farrell to Dr A Banerjee (26.02.20)
[39] Exhibit 1, Vol. 1, Tabs 15.10, SJOG Progress Notes (10.00 pm, 05.02.20)
[40] Exhibit 1, Vol. 1, Tab 10.1, Letter Dr S Jana (05.06.20)
[41] Exhibit 1, Vol. 1, Tab 6, Statement - Ms W James (09.02.20), para 23
[42] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20)
[43] Exhibit 1, Vol. 1, Tab 25, Statement - Dr G Farrell (22.03.23), paras 50-51

27. When Ms James collected Mr Taulelei from SJOG, she says that other than being told verbally that he had been referred to MACMHS, she was given no further information about his discharge plan and did not receive any documentation (such as a copy of the discharge plan). When she got him home, Ms James described Mr Taulelei as "*so tired*" and said that his mood was "*very low*".[44]

28. In any case, Dr Farrell's referral to MACMHS was emailed to the service at 10.41 pm on 5 February 2020,[45] and reviewed by a triage officer on 6 February 2020. The triage officer noted Mr Taulelei had been referred to the service on several occasions in the past year and had declined to comply with various recommendations about engaging with a psychologist, pain management, and lifestyle modifications. The MACMHS triage officer called Mr Taulelei's mobile to discuss the referral at 12.39 pm on 6 February 2020, there was no reply and so a message was left asking Mr Taulelei to call back. The plan was to write to Mr Taulelei if he did not do so.[46,47]

GP Consultation - 6 February 2020[48,49,50]

29. Ms James says that as Mr Taulelei was "*still struggling*" she took him to see his GP (Dr Chudasama) at 1.35 pm on 6 February 2020. Mr Taulelei disclosed his suicide attempt the previous day, and that the main trigger had been his son's birthday. Although Mr Taulelei said he no longer had had "*suicidal intent*", he said he was still experiencing "*strong suicidal thoughts*".

30. Ms James says Dr Chudasama was "*worried enough that he wanted to call the emergency mental health team, but Jacob promised he would go back to hospital if things got worse*".[51] Instead, Dr Chudasama referred Mr Taulelei to a psychiatrist at Hollywood Private Hospital (as an outpatient) and prescribed duloxetine (an antidepressant), and a low dose of quetiapine (a tranquilising antipsychotic).

[44] ts 30.03.23 (James), pp205-206
[45] Exhibit 1, Vol. 1, Tab 16.3, Email - Dr G Farrell (05.02.20)
[46] Exhibit 1, Vol. 1, Tab 16.4, MACMHS Mental Health Triage form (06.02.20)
[47] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), p16
[48] Exhibit 1, Vol. 1, Tab 12, Report - Dr A Chudasama (09.03.20)
[49] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), pp16-17
[50] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), p16
[51] ts 30.03.23 (James), p206

Attendance at SJOG - 7 February 2020[52,53,54,55,56,57,58]

31. Just before 6.00 pm on 7 February 2020, Mr Taulelei sent his mother a Facebook message that contained a link to a song he said he wanted played at his funeral. Understandably, Ms James became very concerned about his mental health, and took him to SJOG. When Mr Taulelei was reviewed by a triage nurse at 8.05 pm, he said he needed to see "*mental health*" because he was "*scared about what he might do*". He told the triage nurse he had presented to SJOG a few days ago "*with cuts to his wrists*" but there had been no available beds. The triage nurse also noted Mr Taulelei said he had no injuries, and that he denied consuming alcohol, medications or illicit drugs.[59,60]

32. Mr Taulelei was moved into a treatment bay in the ED at about 8.55 pm and reviewed by a registered nurse. He told the nurse he had been "*feeling low*" over the past week and had suicidal thoughts. He said he had been seen at SJOG "*a few days ago*" with suicidal thoughts and that his plan to take his life was the same, although he declined to elaborate. The nurse noted Mr Taulelei's flat affect, his limited eye contact, and his brief responses to questions.[61]

33. Mr Taulelei was seen by an ED registrar (Dr Fred English) at about 9.30 pm. From his entry in the medical notes, it is clear Dr English was under the impression Mr Taulelei had been seen by his GP and a mental health service that day for "*ongoing suicidality*", but as I have explained, this was not the case. Mr Taulelei told Dr English he had started some medication prescribed by his GP that day but was still experiencing "*ongoing thoughts of suicide*". Mr Taulelei told Dr English he wanted to jump in front of a train and that he had a train timetable (so presumably knew when trains would be passing).[62,63]

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[52] Exhibit 1, Vol. 1, Tab 6, Statement - Ms W James (09.02.20), paras 16-26 and ts 30.03.23 (James), pp206-210
[53] Exhibit 1, Vol. 1, Tab 10.1, Letter Dr S Jana (05.06.20)
[54] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr F English (9.31 pm, 07.02.20)
[55] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), pp17-19
[56] Exhibit 1, Vol. 1, Tab 26, Statement - Dr S Curtin (22.03.23), para 45 and ts 28.03.23 (Curtin), pp49-56
[57] Exhibit 1, Vol. 1, Tab 27.1, Statement - Dr F English (22.03.23), paras 10-33 and ts 28.03.23 (English), pp67-78
[58] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), pp17-21 and ts 29.03.23 (Sharma), pp97-156
[59] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), p17
[60] Exhibit 1, Vol. 2, Tab 29.12, webPAS entry (8.05 pm, 07.02.20)
[61] Exhibit 1, Vol. 1, Tab 15.2, SJOG ED Record (8.55 pm, 07.02.20)
[62] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr F English (9.31 pm, 07.02.20)
[63] Exhibit 1, Vol. 1, Tab 27.1, Statement - Dr F English (22.03.23), para 33

34. Dr English's assessment was that Mr Taulelei had an "*abnormal mental state (+)*" and that he displayed marked suicidality with an organised plan that had "*a high degree of lethality*". Dr English noted that Mr Taulelei was willing to be admitted to hospital and there were no underlying toxicological, medical or traumatic causes for this presentation. Other than the injury to his hand, Mr Taulelei was assessed as "*physically well*" and Dr English's view was that Mr Taulelei should be reviewed by the psychiatric team and admitted to the MHU.[64]

35. In an email to Dr Matthew Summer-Scales dated 13 February 2020, Dr English described Mr Taulelei as having a "*fixed plan of high lethality that was easily executable*". Dr English said that he assessed Mr Taulelei's risk of suicide as "*extremely high*" and for that reason, had referred Mr Taulelei to the mental health team "*immediately*".[65] At the inquest, Dr English said this about Mr Taulelei's presentation:

> In an academic sense Jacob's risk factors would be labelled as extreme. If you were to take a textbook of risk factors, Jacob had them all…I know Jacob presented with his mother. When I spoke to him initially he was alone. He was speaking in a very low volume. He had a plan which entailed not only actionability but a very high degree of lethality. Apart from his family who clearly cared for him, and he clearly cared for them, he had very limited protective factors against suicide.[66]

36. Dr English says he told Dr Farrell that Mr Taulelei had said he was planning to "*jump in front of a freight train*", and she had replied that "*this was possible in this locality*", and agreed admission "*was warranted*". Although Dr Farrell could not recall this conversation "*exactly*", she said she would have told Dr English she was familiar with Mr Taulelei's case (having seen him two days previously) and would review him "*when she got the opportunity*". At the time of her conversation with Dr English, Dr Farrell was completing some medical notes, and she confirmed that the handover was verbal not written.[67,68]

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[64] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr F English (9.31 pm, 07.02.20)
[65] Exhibit 1, Vol. 2, Tab 29.17, Email - Dr F English to Dr M Summer-Scales (13.02.20)
[66] ts 28.03.23 (English), p67
[67] Exhibit 1, Vol. 2, Tab 29.17, Email - Dr F English to Dr M Summer-Scales (13.02.20)
[68] Exhibit 1, Vol. 2, Tab 29.18, Email - Dr G Farrell to Dr A Banerjee (26.02.20)

37. Dr English made the following entry in the medical notes: "*D/W* (discussed with) *psych* (psychiatric team) - *pt* (patient) *known to them, will see and admit*".[69] Given that this notation was made shortly after Dr English had spoken with Dr Farrell, it seems sensible to conclude that the entry accurately records aspects of their conversation. In his statement to the Court, Dr English said he had "*confidence*" in Dr Farrell and "*understood it had been agreed*" that Mr Taulelei wanted to be admitted to the MHU, and that this would occur. For those reasons, Dr English said he did not think it was necessary (or appropriate) to detain Mr Taulelei at SJOG involuntarily.[70,71]

38. Dr English also submitted a "*bed slip*" to alert hospital staff that Mr Taulelei required admission.[72] At the inquest, Dr English said submitting a bed slip for a mental health patient was an unusual step for him to take as an ED registrar, and the "*vast majority*" of such admissions require a "*mental health-led determination*". However, Dr English said it was "*so clear*" Mr Taulelei should be admitted and at the inquest, he noted:

> The importance of it (i.e.: submitting the bed slip) is I wouldn't do that very often, and I wouldn't have done it unless I thought: (a) Jacob wanted to come to hospital, and (b) that it would have been very odd for somebody to disagree with that, or something was going to have to change. And to the best of my recollection I put the bed slip in after I spoke to Jacob's mother.[73]

39. In his statement to the Court, Dr English said with the benefit of hindsight there was some additional detail he could have written in his medical notes, including the fact that Mr Taulelei told him he actually had a train timetable, which clearly indicates a degree of planning. Although this was not recorded in his medical notes, Dr English says he is confident he passed on this information verbally to Dr Farrell and the incoming ED registrar, Dr Shona Curtin.[74]

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[69] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr F English (9.31 pm, 07.02.20)
[70] Exhibit 1, Vol. 1, Tab 27.1, Statement - Dr F English (22.03.23), paras 23-24
[71] Exhibit 1, Vol. 2, Tab 29.17, Email - Dr F English to Dr M Summer-Scales (13.02.20)
[72] See: ts 29.03.23 (Schutte), pp183-184
[73] ts 28.03.23 (English), p70
[74] Exhibit 1, Vol. 1, Tab 27.1, Statement - Dr F English (22.03.23), para 33

40. Dr English said he told Ms James that Mr Taulelei would be seen by a psychiatric registrar and admitted to the MHU. After she had spoken with Dr English, Ms James said she felt Mr Taulelei "*was safe*".[75] She also believed, quite reasonably, that her son would be admitted to the MHU. So it was that when Mr Taulelei told his mother to go home, she felt comfortable to do so.

41. Before Dr English left SJOG at about 10.30 pm, he handed over Mr Taulelei's care to Dr Curtin. In a retrospective entry made at 8.50 am on 8 February 2020, Dr Curtin confirmed receiving a handover from Dr English. Dr Curtin noted Mr Taulelei had expressed suicidality, and was for voluntary admission to the MHU. Dr Curtin's entry also mentions that an x-ray of Mr Taulelei's hand had been ordered. SJOG records establish the x-ray was performed and that Mr Taulelei returned to the ED at about 10.40 pm.

42. In an entry in the webPAS system at 10.00 pm, Dr Curtin recorded the following details about Mr Taulelei's presentation:

> 2200 h/o: 28M seen here during the week and sent home. Increasingly suicidal since. Background regional pain syndrome. For X-Ray left hand. Voluntary but not to leave".[76]

43. In his statement to the Court, Dr English reiterated the fact that he understood there was "*a clear plan agreed between myself, Dr Farrell, Dr Curtin and the Patient*" that Mr Taulelei would be admitted. Dr English also said it never occurred to him that Mr Taulelei would be discharged, but that if he was, that Dr Curtin and Ms James would be contacted first.[77]

44. I note that Dr Curtin's retrospective entry in the medical notes supports Dr English's position, and states: "*Patient was seen by (psychiatric) registrar. I was not informed by (psychiatric) registrar or other member of staff about patient's discharge*".[78]

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[75] ts 30.03.23 (James), p207 and see also: Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), p12
[76] Exhibit 1, Vol. 2, Tab 29.12, Screenshot of webPAS entry (10.00 pm, 07.02.20)
[77] Exhibit 1, Vol. 1, Tab 27.1, Statement - Dr F English (22.03.23), para 33
[78] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr S Curtin (8.50 am, 08.02.20)

45. Dr Farrell did not have the opportunity to review Mr Taulelei before the end of her shift and she handed his case over to the incoming psychiatric registrar, Dr Mrinalini Sharma. At the inquest, Dr Sharma confirmed she was employed at SJOG on a casual basis, and usually worked there one night per week. Dr Sharma also confirmed she had been working in psychiatry since 1995, as a psychiatric registrar in Perth since 2000 and working casual evening shifts at SJOG since about September 2017.[79]

46. At the time of the handover of Mr Taulelei's case, Dr Farrell was completing "*paperwork*" and she has been unable to recall how much detail she relayed to Dr Sharma. Nevertheless, she believes that although she told Dr Sharma she (Dr Farrell) had seen Mr Taulelei two days before, she would not have commented on his suicidality because she (Dr Farrell) had not reviewed him that evening.[80]

47. In her email to Dr Banerjee on 24 February 2020, Dr Sharma confirmed she received a handover from Dr Farrell and was told Mr Taulelei had presented to SJOG two days earlier. Dr Sharma says she reviewed Mr Taulelei's notes and checked his history on PSOLIS,[81] before assessing him in his ED cubicle at about 11.15 pm.[82] At the inquest, Dr Sharma "*particularly recalled*" Dr English's notes were not available, and seemed surprised that a nurse had not been allocated to monitor Mr Taulelei if his risk (as assessed by Dr English) "*was so high*".[83,84]

48. Dr Sharma described Mr Taulelei as "*narcissistic, angry and avoidant*" when she asked him about the events that had led to him attending SJOG that evening and noted his suicidal thoughts that were related to his son's birthday. In her email to Dr Banerjee, Dr Sharma said that Mr Taulelei's "*suicidal ideas*" were always present, but that he had "*no intent or plan*". Dr Sharma also said Mr Taulelei was "*cooperative*" and that they had also discussed his chronic pain and his treatment with opiate medication. At the inquest, Dr Sharma said her review of Mr Taulelei had taken about 20 minutes.[85]

[79] ts 29.03.23 (Sharma), pp86-87, 90 & 146 and Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), p12
[80] Exhibit 1, Vol. 2, Tab 29.18, Email - Dr G Farrell to Dr A Banerjee (26.02.20)
[81] Psychiatric Services Online Information System which contains a summary of a patient's psychiatric history and risk factors
[82] Exhibit 1, Vol. 2, Tab 29.19, Email - Dr M Sharma to Dr A Banerjee (24.02.20)
[83] Dr Schutte said Dr Sharma bore the onus of tracking down any missing medical notes: ts 29.03.23 (Schutte), p189
[84] ts 29.03.23 (Sharma), pp102-103
[85] ts 29.03.23 (Sharma), pp113-114, and see also: Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), p19

49. Dr Sharma's assessment was that Mr Taulelei had "*an adjustment disorder in the context of crisis in his life*". Although his poor engagement with community mental health services was noted, Dr Sharma's entry in the Mental Health Triage form states she "*discussed outpatient care with psychologist as mainstay of therapy, which he did reluctantly acknowledge*".[86]

50. As noted earlier, following his review at 9.30 pm, Dr English assessed Mr Taulelei's risk factors as "*extreme*" and found he had "*very limited protective factors against suicide*".[87] Nevertheless, as part of her assessment Dr Sharma completed a BRA and determined Mr Taulelei's suicide risk was "*low*".[88] Notably, the BRA Dr Sharma completed did not refer to Mr Taulelei's history of deliberate self-harm, notwithstanding the fact that this was mentioned in his Mental Health Triage form.[89,90]

51. Dr Sharma's medical notes included the following entry:

> Patient presents in crisis, currently no grounds to hold under MHA (*Mental Health Act 2014* WA). Dx: (Diagnosis) Adjustment disorder. CMHS (Community Mental Health Service) follow up for ongoing psychological and medical Mx (management).[91]

52. In a retrospective entry in the progress notes marked "*7.00 am*" (presumably made on 8 February 2020), Dr Sharma provided some detail about her assessment of Mr Taulelei. In that entry, Dr Sharma asserts Mr Taulelei was "*calm*" by the end of her review, and that he had agreed to be followed up by his psychologist, with whom he said he had an appointment on 10 February 2020. The entry also states Mr Taulelei was aware his problems with access to his child would not be resolved in hospital, and that he had said "*no one could help as he has no idea where the mother or the child are currently*".[92]

[86] Exhibit 1, Vol. 1, Tab 15.5, SJOG Triage Form (07.02.20)
[87] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr F English (9.31 pm, 07.02.20)
[88] Exhibit 1, Vol. 1, Tab 15.6, Brief Risk Assessment (created at 3.26 am on 08.02.20)
[89] ts 28.03.23 (English), p67
[90] Exhibit 1, Vol. 1, Tab 15.5, SJOG Triage Form (07.02.20)
[91] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr S Sharma (11.15 pm, 07.02.20)
[92] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr S Sharma (7.00 am, 08.02.20)

53. In relation to her review of Mr Taulelei, Dr Sharma said he told her he was not suicidal and did not want to "*come into the hospital*". Further, although Mr Taulelei was "*ambivalent about psychology*" and said he "*knew more than the psychologist*", he had accepted psychological follow up.[93]

54. In her retrospective entry, Dr Sharma also noted Mr Taulelei told her he "*could be safe at home*" and would follow up with "*community mental health services*". After again mentioning that in her opinion there were no grounds to detain Mr Taulelei (i.e.: under the MHA), Dr Sharma noted that Mr Taulelei had agreed to be discharged home. Dr Sharma's entry concludes: "*Discussed with ED staff*".[94]

55. At the inquest, Dr Sharma confirmed that she had been unable to locate Dr Curtin (who was presumably busy attending to other patients), and so she told the ED "*nurse shift coordinator*" that Mr Taulelei was "*safe to discharge*".[95] In passing I note that in her email to Dr Banerjee, Dr Sharma said the shift coordinator she would usually handover to "*wasn't around*" and that she "*had informed the 2 nurses who were looking after him that shift that he was leaving and there were no grounds to hold him under the Act*.[96,97]

56. At the inquest Dr Sharma was asked whether it would have been beneficial for her to speak with the ED registrar before "*recommending*" Mr Taulelei's discharge and her response was:

> Yes, but I did not recommend the discharge. All I had to say… what I said to the nurse is that the patient does not want to actually stay back. He wants to be discharged, and therefore I do not have any grounds (to detain) him against his will…But I was not discharging him.[98]

[93] 15.4, SJOG Progress Notes, Dr S Sharma (7.00 am, 08.02.20)
[94] Exhibit 1, Vol. 1, Tab 15.4, SJOG Progress Notes, Dr S Sharma (7.00 am, 08.02.20)
[95] Dr Curtin was unaware Mr Taulelei had been discharged until she was advised of his death
[96] Exhibit 1, Vol. 2, Tab 29.19, Email - Dr M Sharma to Dr A Banerjee (24.02.20)
[97] In this context, Dr Sharma's use of term "*the Act*" is clearly a reference to the *Mental Health Act 2014* (WA)
[98] ts 28.03.23 (Sharma), p122

57. For his part, Dr English emphasised the importance of clear communication between the ED registrar and the clinician the patient is being referred to. In Mr Taulelei's case, this was to ensure the psychiatric team had all relevant information, and so that the case could be escalated to the consultant psychiatrist in the event of any disagreement about the proposed discharge plan. Dr English said: "*it would have been reasonable, if not more than reasonable, for a member of the mental health team to have communicated with a member of the emergency department team prior to* (Mr Taulelei's) *discharge*.[99]

58. It is at least possible that had Dr Sharma advised Dr Curtin she was not planning to admit Mr Taulelei to the MHU, then Dr Curtin might have challenged Dr Sharma's decision, and/or have requested that the consultant psychiatrist be consulted.

59. In his letter to the family, Dr Jana states Mr Taulelei told Dr Sharma "*he did not want to be admitted to hospital*" and had an appointment with his psychologist on 10 February 2020. Dr Jana says Mr Taulelei told Dr Sharma "*he was not suicidal*" and would "*be safe at home with his mother*". Dr Jana also noted that although Dr Sharma had asked Mr Taulelei if his mother could be called, he "*did not agree to this*".[100]

60. At the inquest, Dr Sharma agreed that although she had said Mr Taulelei had told her he did not want her to speak with his mother, this was not mentioned in her notes. When asked if she agreed this was a significant matter, her response was "*Yes, perhaps*".[101]

61. So it was that despite Mr Taulelei's second mental health presentation in three days, he was discharged home from SJOG at 11.57 pm on 7 February 2020.[102] Further, despite Ms James specifically asking to be told if Mr Taulelei left SJOG, this did not occur and so Mr Taulelei set off into the night alone.[103]

[99] ts 28.03.23 (English), pp74-75
[100] Exhibit 1, Vol. 1, Tab 10.1, Letter Dr S Jana (05.06.20), p3
[101] ts 28.03.23 (Sharma), p125
[102] Exhibit 1, Vol. 2, Tab 29.12, Screenshot of webPAS entry (11.57 pm, 07.02.20)
[103] ts 30.03.23 (James), pp208-209

Mr Taulelei is struck by a train[104,105,106,107,108,109,110]

62. At 12.06 am on 8 February 2020, Mr Taulelei posted a photo of train tracks to his Facebook account, and at 12.21 am he posted a message indicating he was going to take his life. At about 12.30 am, a freight train was travelling west through the Lloyd Street overpass adjacent to Railway Parade in Midland, just a few metres from SJOG.

63. At that time, Mr Taulelei was lying in the centre of the train tracks and when the driver saw him, he immediately applied the train's brakes. Mr Taulelei was seen to stand up and face the train briefly before he turned and "*walked towards Railway Parade*". Tragically, before the train could be brought to a stop, it struck and killed Mr Taulelei.

CAUSE AND MANNER OF DEATH[111,112,113]

64. On 12 February 2020, two forensic pathologists (Dr Clive Cooke and Dr Joe Ong) conducted an external post mortem examination and reviewed CT scans. They found Mr Taulelei had sustained multiple soft tissue injuries to his head, torso and limbs and fractures of his skull, limbs and ribs. Toxicological examination found therapeutic levels of amitriptyline, diazepam, duloxetine, oxycodone, paracetamol and quetiapine in Mr Taulelei's system, along with low levels of oxazepam and ondansetron. Alcohol and other common drugs were not detected.

65. At the conclusion of their external post mortem examination, Dr Cooke and Dr Ong expressed the opinion that the cause of Mr Taulelei's death was multiple injuries. I accept and respectfully adopt the conclusion reached by Dr Cooke and Dr Ong as my finding in relation to the cause of Mr Taulelei's death. Further, in view of all of the available evidence, I find Mr Taulelei's death occurred by way of suicide.

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104 Exhibit 1, Vol. 1, Tab 7, Statement - Driver of the freight train (08.02.20)
105 Exhibit 1, Vol. 1, Tabs 14.1 & 14.2, Facebook posts - Mr J Taulelei (08.02.20)
106 Exhibit 1, Vol. 1, Tab 2, Memo - Const. S Warhurst (17.04.20)
107 Exhibit 1, Vol. 1, Tab 8, Memo - Sen. Const. D Saunders (08.02.20)
108 Exhibit 1, Vol. 1, Tabs 9.1 & 9.2, St John Ambulance Patient Care Records (MID21N2 & CSS01N2, 08.02.20)
109 Exhibit 1, Vol. 1, Tab 3.1, Life Extinct Form (08.02.20)
110 Exhibit 1, Vol. 1, Tab 3.2, P92 Identification of Deceased Person - Other than by Visual Means(11.02.20)
111 Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (27.03.20)
112 Exhibit 1, Vol. 1, Tab 4.2, Post Mortem Report (12.02.20)
113 Exhibit 1, Vol. 1, Tab 5.1, Final Toxicology Report (23.03.20)

MR TAULELEI'S MANAGEMENT AT SJOG

Clinical review - SAC1[114]

66. The investigating panel conducting the clinical investigation that followed Mr Taulelei's death (SAC1) examined the care he received and the decisions to discharge him on 5 February 2020 and 7 February 2020. The investigating panel finalised their enquiries on 19 March 2020.

67. In relation to his presentation on 5 February 2020, the panel concluded that Mr Taulelei had received appropriate care, but that his management plan "*appeared to change as there were no available beds*". The panel agreed that a "*failing*" during this presentation was not establishing whether any voluntary mental health beds were available "s*tate-wide*", and the SAC1 also noted:

> The patient stated he was not comfortable with the noise in the busy ED environment (and) the panel agreed that if there was no delay in being admitted, it may have supported his decision to stay for assessment and ongoing treatment.[115]

68. As to Mr Taulelei's treatment at SJOG on 7 February 2020, the panel concluded that this presentation "*raised more concerns*" and they identified "*multiple contributing factors*" that had led to Mr Taulelei's "*adverse outcome following discharge*", namely:

> Hand over processes: ED to psychiatry, and psychiatry to psychiatry;
>
> Failure to escalate to the duty consultant, document assessment and develop a management plan;
>
> No clear formulation of risk and subsequent planning;
>
> Inadequate discharge planning;
>
> No inclusion of collateral sources of information regarding history and risk information e.g., family; and
>
> Poor quality and limited contemporaneous clinical documentation.[116]

[114] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20)
[115] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20), p11
[116] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20), p11

69. The panel identified that the delay in Mr Taulelei being reviewed by the psychiatric registrar (Dr Sharma) was due to "*activity in the ED*". The panel also noted there was no written handover between "*the registrars*", but that Dr English had recommended that Mr Taulelei be held in the ED under "*duty of care*" if he (Mr Taulelei) tried to leave.

70. The panel considered that the documentation in the medical notes relating to Mr Taulelei's presentation on 7 February 2020 was "*substandard*" and that the majority of it was written retrospectively. Further, the panel found the BRA completed by Dr Sharma was "*inaccurate in relation to static and dynamic factors. Protective factors were not identified, and the formulation of risk and plan of management were unclear*".[117]

71. The panel also found that the policy requiring patients who presented with suicidality be "*escalated to the duty consultant*" had not been followed. The panel emphasised the importance of involving the duty consultant in Mr Taulelei's case because he had presented to the ED twice in a matter of days. However, the panel noted that Dr Sharma was employed on a casual basis and that the process for ensuring casual staff were aware of policies and procedures "*requires improvement*".[118]

72. Although Mr Taulelei was referred to MACMHS when he presented to SJOG on 5 February 2020, the panel noted that this did not occur following his presentation on 7 February 2020. Dr Sharma had told the panel that her plan was to handover to the morning team and ask them to contact MACMHS, but as noted in the SAC1, her plan was "*not documented in the clinical notes*".

73. The panel noted with approval that Dr Farrell had obtained collateral information about Mr Taulelei's condition from his mother, and had consulted her about his discharge on 5 February 2020. In contrast, as I have explained, this did not occur during Mr Taulelei's second presentation to SJOG on 7 February 2020.

74. After Dr English told Ms James her son would be admitted to the MHU on 7 February 2020, Ms James was told nothing about his amended

[117] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20), p12
[118] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20), p12

discharge plan. The panel noted that Mr Taulelei had refused to allow his mother to be contacted but determined it would still have been possible for Ms James to have been provided with information "*regarding crisis actions and observations of the patient without breaching lack of consent or confidentiality*".[119]

75. Further, whilst acknowledging Mr Taulelei was "*angry and upset and stated he would find his own way home*", the panel questioned "*if further negotiation was necessary to convince the patient to stay*" and agreed that Mr Taulelei's mother "*should have been involved or in the very least contacted to state that the patient was being discharged*".[120,121]

76. The panel found that Mr Taulelei's discharge plan on 7 February 2020 was "*substandard*" and not in accordance with relevant policy. The panel also noted that Dr Sharma's decision to ask nursing staff to "*inform the ED doctors the patient had left*" when she had been unable to locate an ED doctor to handover to, "*was not conducive to a team-based approach to providing multi-disciplinary patient care and not in line with the framework*". The panel also said: "*Overall, it was agreed that communication between staff, to the patient and the family, and external agencies was poor. The panel agreed that the overall assessment on 7th February and the subsequent discharge planning was not in line with the ED PLS* (Psychiatric Liaison Service) *framework*".[122]

77. Following their investigation, the panel made four recommendations. The first dealt with improvements to the orientation for psychiatry medical officers in the ED to ensure compliance with relevant policies and procedures. The second related to reviewing supervision guidelines for junior psychiatry medical officers, and roster changes to minimise the reliance on casual employees. The third was about written handovers between ED and mental health staff, and the fourth related to enhancing the referral procedure to community mental health services.[123]

[119] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20), p14
[120] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20), p15
[121] I note that Dr Farrell spoke with Ms James during the presentation on 5 February 2020
[122] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20), p15
[123] Exhibit 1, Vol. 1, Tab 10.2, SAC1 Clinical Incident Investigation Report (19.03.20), pp20-23

Dr Hall's assessment[124]

78. Dr Mark Hall (a consultant forensic psychiatrist) provided the Court with a detailed report assessing Mr Taulelei's care, and he also gave evidence at the inquest. In broad terms, Dr Hall agreed with the findings of the SAC1, and he made the following pertinent observations:

a. *First presentation - 5 February 2020*: At the inquest Dr Hall described Mr Taulelei's presentation as "*suggestive of quite a seriously depressed mood*" and noted that the rapid improvement in his mental state was "*a suspicious turnaround, a very stark turnaround*" and his claims that he was better should have ben treated with "*caution and suspicion*". Dr Hall said Dr Farrell's decision to admit Mr Taulelei had been "*appropriate*", but that Mr Taulelei's dramatic improvement and (specifically) his request to be discharged meant his case should have been discussed with the on-call consultant psychiatrist.[125] In her statement to the Court, Dr Farrell said she could not recall if she considered calling the on-call psychiatrist, but that this was her usual practice if she needed advice particularly when she was concerned about patient safety.[126,127]

b. *Second presentation - 7 February 2020*: Dr Hall noted this was Mr Taulelei's second presentation to SJOG in three days, and that he was an acutely distressed man with suicidal thinking that involved "*explicit consideration of method*". Mr Taulelei was accompanied by his mother who was expressing concern and on that basis alone, "*you would always be resigned to admitting him to hospital*".[128] Dr Hall also noted that Mr Taulelei had started taking antidepressant medication that day, and that it is "*common clinical knowledge that the risk of suicide associated with depressed mood escalates, for a variety of reasons, in the period (days to weeks) immediately following commencement of antidepressant medication*". Dr Hall said that in these circumstances, it is appropriate clinical practice to assume that Mr Taulelei was "*at high risk of attempted suicide regardless of any self-reported assurances to the contrary*".[129]

[124] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), pp19-23 and ts 29.03.23 (Hall), pp160-179
[125] ts 29.03.23 (Hall), p162
[126] Exhibit 1, Vol. 1, Tab 25, Statement - Dr G Farrell (22.03.23), para 55 and see also ts 28.03.23 (Farrell), p13
[127] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), p19
[128] ts 29.03.23 (Hall), p164
[129] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), p20

Dr Hall said in his opinion, Mr Taulelei's second presentation on 7 February 2020 "*was such that an admission to hospital was indicated*", and had Mr Taulelei sought discharge prior to being admitted to the MHU, there should have been a discussion between Dr Sharma and the on-call consultant psychiatrist.

At the inquest, Dr Hall said that given the context of Mr Taulelei's second presentation, "*it should have been apparent at that stage that there really could have been nothing that* (Mr Taulelei) *could have said - or there should have been nothing that* (he) *could say to avert an admission at that stage. It* (i.e.: Mr Taulelei's admission) *should have been a foregone conclusion*".[130]

Dr Hall also noted that Dr Sharma's 20-minute assessment of Mr Taulelei was insufficient if the aim was "*to clear him for discharge*". Dr Hall said in those circumstances, you would "*have to resign yourself to the fact that this is not going to be a quick assessment*" and that Mr Taulelei's mother "*who clearly brought him in*" would be called.[131] Dr Hall also said that if Dr Sharma had discussed Mr Taulelei's discharge with Dr Curtin (something Dr Hall described as "*standard practice*", "*safe*" and "*courteous*") this "*might have prompted a reconsideration of the circumstances, or at least a phone call to the on-call consultant psychiatrist.*[132]

79. In his report, Dr Hall also answered questions from the Court, and taking account of those answers and his evidence at the inquest he considered:

a. Mr Taulelei should have been admitted when he presented to SJOG on 7 February 2020;

b. Dr Sharma (if not Dr Farrell) should have contacted the on-call psychiatrist and if Mr Taulelei had asked to be discharged during his second presentation, he should have been detained under the MHA "*pending review by a consultant psychiatrist*"; and

c. Mr Taulelei's mother should have been contacted and advised that Mr Taulelei was to be discharged on 7 February 2020.[133]

[130] ts 29.03.23 (Hall), p166
[131] ts 29.03.23 (Hall), p169
[132] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), pp20-21 and ts 29.03.23 (Hall), p172
[133] Exhibit 1, Vol. 1, Tab 11.1, Report - Dr M Hall (11.07.22), pp22-24 and ts 29.03.23 (Hall), pp177-179

Dr Schutte's observations[134]

80. Dr Stefan Schutte (SJOG's Head of Department, Psychiatry) provided the Court with a detailed report and gave evidence at the inquest. In his report, Dr Schutte addressed a number of questions which had been posed by the Court. The issues Dr Schutte addressed were:

a. *Mr Taulelei's discharge on 7 February 2020*: Dr Schutte said that at a minimum, he would have expected that for a presentation like Mr Taulelei's, the assessing clinician (i.e.: Dr Sharma) should have tried to convince the patient to allow a family member or carer to be contacted.[135] and that the patient could be escalated to the on-call consultant psychiatrist for guidance. As Dr Schutte noted, contacting Mr Taulelei's family would have given Dr Sharma the opportunity to obtain more information about Mr Taulelei's risk of suicide. Further, Dr Schutte noted that Dr Sharma's entry in the medical notes does not refer to her having made enquiries with Mr Taulelei as to where he was going after his discharge, or his plans for the next few days. There is also no record of what steps Mr Taulelei would take if he was in crisis again;

b. *Mr Taulelei's apparent refusal to allow his mother to be contacted*: Dr Schutte noted that relevant guidelines encouraged the involvement of a patient's family, carer or support person "*as appropriate*". Dr Schutte noted that clinicians had to balance patient autonomy and confidentiality on one hand, versus risk on the other. As I have already noted, Dr Sharma did not contact Ms James before Mr Taulelei was discharged home on 7 February 2020. At the inquest, Dr Schutte noted:

> [G]iven the situation, it was very clear that Jacob's mother was involved so there is an expectation to communicate back with the family;[136]

81. In her email to Dr Banerjee, Dr Sharma expressed "*sincere regret and condolences to the grieving family*", and said that in future, she hoped "*to override the patient's consent to contact family*".[137]

[134] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), pp27-30 and ts 29.03.23 (Schutte), pp183-196
[135] With the benefit of hindsight, Dr Sharma agreed Ms James should have been called: ts 29.03.23 (Sharma), p112
[136] ts 29.03.23 (Schutte), p189 and see also: ts 29.03.23 (Schutte), p190
[137] Exhibit 1, Vol. 2, Tab 29.19, Email - Dr M Sharma to Dr A Banerjee (24.02.20)

c. *Communication issues*: Dr Schutte noted it was not uncommon for ED clinicians to be unavailable to receive handovers from other clinicians.[138] However, Dr Schutte said he would have expected a psychiatric registrar to "*take particular care*" when handing over a patient like Mr Taulelei as "*low risk*", when Mr Taulelei had been previously assessed by the ED registrar as "*high risk*". Dr Schutte also pointed out that speaking directly to the ED registrar would have "*allowed for a discussion about differences of opinion about the patient's risk*";[139]

d. *Conducting psychiatric assessment in ED cubicles*: Dr Schutte acknowledged that the two areas available in the ED (a room behind the triage area, and a "*family*" room) are not ideal locations to conduct mental health assessments, and referred to SJOG's plans to construct a dedicated mental health emergency centre to address privacy concerns as well as other issues. Dr Schutte also noted it was not unreasonable for a clinician to conduct an assessment in a "*less private setting*" where the patient has a "*particular history of certain behaviours*" (e.g.: aggression);[140,141]

e. *ED checklists and procedures*: Dr Schutte noted that ED staff managing mental health patients use a discharge checklist to ensure that all necessary tasks are completed.[142] Further, there is now a written procedure that clarifies the roles and responsibilities of ED clinicians managing mental health patients;[143,144] and

e. *ED pressure*: Dr Schutte noted the ED at SJOG is very busy and that clinicians are "*under a lot of pressure in terms of the number of presentations*". Dr Schutte said that when there were limited (or no) beds in the MHU, "*there is a risk that the clinician may perform an assessment influenced by those factors and therefore rationalise a plan to achieve that outcome*". Dr Schutte noted that the PROTECT training course (discussed later in this finding) includes a module on "*rational*" as opposed to "*rationalising*" decision making to assist clinicians to deal with these sorts of risks.

[138] See also: ts 28.03.23 (Farrell), pp17-18 & 35-36
[139] Dr Sharma though Mr Taulelei's personality disorder might explain his variable mental state: ts 29.03.23 (Sharma), pp116-117
[140] ts 29.03.23 (Schutte), pp184-185 and 189, and see also: ts 28.03.23 (Farrell), pp13-14
[141] Dr Sharma said "*previous aggression*" was why she assessed Mr Taulelei in his ED cubicle: ts 29.03.23 (Sharma), p110
[142] Exhibit 1, Vol. 2, Tab 29.25, ED PLS Discharge Checklist
[143] ts 29.03.23 (Schutte), p189
[144] Exhibit 1, Vol. 2, Tab 29.26, Mental Health process in ED (May 2021)

Comments regarding Mr Taulelei's management

82. When assessing Mr Taulelei's treatment at SJOG, and in particular whether to make an adverse finding in relation to any person's conduct, I must be mindful of two key principles. The first is the phenomenon known as hindsight bias, which is the common tendency to perceive events that have occurred as having been more predictable than they actually were.[145]

83. The other relevant principle is known as the Briginshaw test, taken from a High Court judgment of the same name, where Justice Dixon stated:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[146]

84. In a nutshell then, the Briginshaw test requires that the more serious the allegation, the higher the degree of probability that is required before I can be satisfied as to the truth of the allegation.

85. I also note that as a result of other inquests I have conducted, I am aware that a person's risk of suicide is unpredictable. This is largely because suicide is a relatively rare event, and it is impossible to predict rare events with any certainty. Instead, clinicians manage risk by conducting risk assessments where they consider historic and dynamic risk factors, although the use of risk assessment tools containing checklists of characteristics has been found to be ineffective. It should also be noted that a person's risk of suicide can (and often does) fluctuate on relatively short time frames.[147,148,149,150]

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[145] See for example: www.britannica.com/topic/hindsight-bias
[146] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362
[147] Principles and Best Practice for the Care of People Who May Be Suicidal, Health Department (2017), pp2-3
[148] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), p26
[149] ts 29.03.23 (Sharma), pp101, 107, 116 & 142-143
[150] For example: Record of Investigation into Deaths at Casuarina Prison (14/19) delivered 22.05.19, paras 119-148

86. Nevertheless, having carefully considered all of the evidence in this matter, including the findings of the SAC1, and the evidence of Dr Hall and Dr Schutte, it seems quite obvious to me that Mr Taulelei should have been admitted to SJOG when he presented on 7 February 2020.

87. Whilst there is also an argument that Mr Taulelei should have been admitted when he presented to SJOG on 5 February 2020, I accept that this issue is more finely balanced. Nevertheless, during both of his presentations, Mr Taulelei clearly expressed his intention to jump in front of a bus or train, something he was obviously able to do given the proximity of train tracks to SJOG.

88. An obvious distinction between the two presentations is that by the time of the second on 7 February 2020, Mr Taulelei's distress had not abated. Another is that during the second presentation, Mr Taulelei made a point of disclosing he had a train timetable, and could therefore be expected to have known the times that trains would be passing. This demonstrates considerable planning, and clearly shows Mr Taulelei's suicide risk was elevated, as Dr English had determined.

89. I am also satisfied that the BRA conducted by Dr Sharma on 7 February 2020 was unsatisfactory for the reasons expressed in the SAC1. Further, it is also clear that because of Ms James' close and obvious involvement in her son's care, she ought to have been contacted before Mr Taulelei was discharged from SJOG just before midnight on 7 February 2020.

90. Therefore, in light of the deficiencies I have outlined, it is my considered view that Mr Taulelei's care at SJOG on 7 February 2020 was demonstrably substandard.

91. Whilst it is impossible to know for sure, it does seem very likely that had Mr Taulelei been admitted to SJOG on 7 February 2020, he would not have died in the manner that he did. However, having made that observation, I feel obliged to observe that because of the mental health issues he was grappling with, it is impossible to know what Mr Taulelei's ultimate life journey might have been.

CHANGES AT SJOG SINCE MR TAULELEI'S DEATH[151]

ED Psychiatric Liaison Service framework[152]

92. In his report, Dr Schutte noted that since Mr Taulelei's death, various improvements had been made at SJOG. The first related to an email Dr Banerjee sent to all MHU doctors and locum doctors in the MHU or ED PLS on 10 February 2020. A copy of the ED PLS framework (the Framework) was circulated, and staff were reminded that the "*high risk patient*" category included psychiatric patients who had presented to the ED "*on repeated occasions in the past 28 days*" as well as patients with a "*complicated psychiatric presentation/history*".

93. Dr Banerjee's email also noted that the Framework made it clear that patients rated as "*high risk*" after a BRA or who were identified as "*complex*" must be assessed by the psychiatry registrar "*and are to be escalated to the Consultant on-call*". In terms of discharging patients who present with suicidal ideation, the email noted that in the BRA, primacy should be given to the lethality of the attempt, the sophistication of the plan and the strength of the patient's expressed intention to die.

94. As to contact with a patient's family, the email reminded doctors that:

> "*[D]uty of care can trump the patient's wish for family members not to be informed*", and that "*It would be prudent to go that extra step and ensure that the patient is discharged to someone's care*".[153]

95. Further, there should be a discussion with "*the concerned family member*" about the fact that the patient is being discharged, and where the patient gives consent, information about their discharge plan should be provided. Dr Banerjee's email also noted: "*the ED team should be informed of the disposition*", and Dr Banerjee sent staff a further email with additional detail on 11 February 2020.[154,155]

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[151] ts 29.03.23 (Schutte), pp183-196
[152] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), pp21-22 and ts 29.03.23 (Schutte), pp190 & 193-194
[153] Exhibit 1, Vol. 2, Tab 29.20, Email - Dr A Banerjee (10.02.20)
[154] Exhibit 1, Vol. 2, Tab 29.20, Email - Dr A Banerjee (10.02.20)
[155] Exhibit 1, Vol. 2, Tab 29.21, Email - Dr A Banerjee (11.02.20)

Staffing issues[156]

96. Dr Schutte noted that since he started working at SJOG (in about May 2021), a consultant psychiatrist has been allocated to the ED on every shift. During business hours the consultant psychiatrist is physically onsite, whereas after hours they are available on an on-call basis. The previous arrangement had been that the five inpatient consultant psychiatrists provided cover to the ED one day each during business hours.

97. Another staff change related to the use of casual or locum psychiatric registrars. Previously, SJOG had relied on a pool of casual or locum psychiatric registrars to work evening shifts and on weekends. Now a rotating roster of five full-time registrars covers all shifts. Although SJOG still relies on locums to cover some shifts (e.g.: occasional absences due to illness), it now uses locums who have had "*prior experience in working in psychiatry*" at SJOG.

98. Dr Schutte also referred to SJOG's plans to increase the number of consultant psychiatrists it employs. SJOG currently has 4.4 full-time equivalent consultant psychiatrists, but funding has been approved to employ a further eight. In addition, in September 2023, a senior doctor at SJOG will be formally recognised as a consultant psychiatrist. Dr Schutte did however note that efforts to recruit consultant psychiatrists had been affected by some recent resignations, and by "*apparent skill shortages*" in Western Australia over the past 18 months.

99. As to supervision, consultant psychiatrists have been reminded of their obligations in relation to trainee psychiatric registrars. Previously, supervision was informal with the junior doctor bearing responsibility for initiating supervision sessions. However, since early 2023, all junior doctors have an appointed supervisor, and regular supervision meetings are conducted. Dr Schutte also advised that medical officers who have not previously worked in psychiatry at SJOG are directly supervised by a senior registrar for one shift in "*a shadowing arrangement*", before being permitted to work after-hours or on weekends.

[156] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), pp22-23 and ts 29.03.23 (Schutte), pp186-187 & 194-196

PROTECT Training[157]

100. Dr Schutte said since May 2022, medical and nursing staff working in psychiatry have been able to attend a two day training course in the "PROTECT" model of care, which deals with suicide prevention by "*proactive detection*". The PROTECT model of care focuses on "*appropriate risk formulation and management*" rather than risk prediction, and seeks to establish a relationship with the patient using "*empathetic communication and understanding a person's pain*".

101. PROTECT training is specifically focussed on the management of suicidal patients, and the expectation is that all SJOG clinical psychiatry staff will complete this training. However, Dr Schutte noted that as yet, not all clinicians have been able to complete the training and it has been challenging to release staff because of "*existing staff shortages*". Nevertheless, he said four training sessions will be offered in 2023.

Daily face-to-face handovers to MACMHS[158]

102. SJOG now conducts daily face-to-face handovers with MACMHS to discuss the management of patients who are active with the service, who have presented to the ED, and/or have been referred to MACMHS. On weekdays, an email is also sent to MACMHS listing SJOG's available beds, expected discharges, and referrals. The email also lists patients who have presented to the ED and their management plans.

Amendments to Framework[159]

103. Dr Schutte said that since Mr Taulelei's death, the Framework has been reviewed and some amendments have been made. Relevantly, referrals to the ED PLS are now made using a written proforma,[160] whereas previously handovers were done verbally. The definition of a "*high risk patient*" (who must be "*escalated*" to the consultant psychiatrist) has also been amended and now includes someone presenting to the ED more than once in the previous seven days, or within 7 days of discharge. Patients presenting in crisis and expressing suicidal ideation with little or no mental health history are also now categorised as "*high risk*".

[157] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), pp23-24
[158] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), p24
[159] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), pp24-27
[160] Exhibit 1, Vol. 2, Tab 29.24, SJOG ED Mental Health Proforma (Written referral to ED PLS)

104. Another change is that the Framework now specifically provides that patients who present with suicidal ideation must be managed in accordance with an assessment and management flowchart that outlines key factors in relation to discharging a psychiatric patient. These include communicating the discharge plan to the senior ED doctor, and the fact that the patient can only be discharged by the senior ED doctor.

105. Any disagreements about the patient's discharge plan can be escalated to the most senior clinician on duty (or on-call). However, where a discharge is agreed, both the patient and an appropriate support person must receive and sign the discharge plan, and a copy is also placed in the patient's medical record. In addition, all patients being discharged from the ED PLS must be referred for appropriate follow up and a copy of all referrals must be placed in the patient's medical record.

106. Another change is patients presenting with "*suspected risk of suicide"* or "*expressing resolved suicidal ideation*" (as Mr Taulelei did) must now be discharged into the care of their carer. Where this is not possible or the patient refuses, a risk assessment must be conducted and the consultant psychiatrist and treating ED doctor must both be informed. A "discharge against medical advice" form must also be completed. Dr Schutte also said that ED PLS staff have been encouraged to adopt "*a low threshold*" in relation to contacting the consultant psychiatrist.

107. Dr Schutte said he thought the Framework was "*helpful*" in setting out the procedure for managing mental health patients in the ED. However, in his view there was too much focus on "*risk stratification*", where patients are categorised by the presence of risk factors as either "*low, medium or high suicide risk patients*".[161] Dr Schutte noted (as mentioned earlier) that the predictive value of suicide risk questionnaires is "*very low*", and a risk stratification approach focuses too much on "*risk prediction and not enough on risk management*". Dr Schutte said that in his view a more effective strategy was "*engaging with the patient*" and conducting "*a thorough individualised assessment*" to identify the factors "*troubling the specific patient*".

[161] ts 29.03.23 (Schutte), p187

108. For that reason, Dr Schutte has proposed further amendments to the Framework to add a range of resources, forms and clinical tools, aimed at (amongst other things) enhancing "*patient engagement*". Another relevant change is that since Mr Taulelei's death, the BRA has been replaced by the "*Risk Assessment and Management Plan*" (RAMP). The RAMP, which was issued by the Department of Health, takes account of a broader range of dynamic factors when assessing risk, and was emailed to SJOG clinical staff on 6 March 2020.[162]

Mental health emergency centre[163,164]

109. Finally, Dr Schutte advised that SJOG is in the planning stages of "*a hospital expansion*" project to cater for "*increasing demands for services*". Part of that project includes the construction of a dedicated mental health emergency centre which would address the ED's current lack of suitable private spaces to conduct assessments.

CONCLUSION

110. It is a truism that the death of a loved one is a sad occasion, but in this case, Mr Taulelei was only 28 years old when he died. The death of such a young man, in such truly awful circumstances, is an almost an unfathomable tragedy.

111. When Mr Taulelei presented to SJOG for the first time on 5 February 2020, he was expressing suicidal thoughts and was clearly distressed. That distress persisted and was worse by the time of his second presentation at SJOG on 7 February 2020.

112. The evidence establishes that Mr Taulelei should have been admitted to SJOG on 7 February 2020, and the fact that he was discharged home, alone, just before midnight without his mother having been called (as she had specifically requested), is profoundly regrettable.

[162] Exhibit 1, Vol. 2, Tab 29.22, Email - Dr A Banerjee (06.03.20)
[163] Exhibit 1, Vol. 2, Tab 29, Report - Dr S Schutte (24.03.23), p31
[164] Exhibit 1, Vol. 2, Tab 29.27, SJOG Mental Health Emergency Centre Project Definition Plan

113. Since Mr Taulelei's death, SJOG have implemented a number of strategies aimed at improving the care offered to patients presenting with mental health issues. Those changes include policy and procedural amendments aimed at enhancing handovers and discharge planning in relation to mental health patients, and improvements to the way a patient's risk of harm is assessed. Changes have also been made to how clinical staff are employed and supervised, and a dedicated mental health emergency centre is also planned. It can only be hoped that these changes achieve their desired aim.

114. However, whilst these changes are welcome, I am very aware that Mr Taulelei's family and his loved ones must continue to deal with the grief and sadness caused by his tragic death. I wish to acknowledge the bravery and resilience displayed by Mr Taulelei's mother, Ms James. At the inquest, she spoke movingly about her beloved son, and her participation honoured his memory. Finally, on behalf of the Court, I wish to extend to Ms James and to her family my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
26 May 2023